

RESEARCH LETTERS

ONLINE FIRST

**HIV Testing in the US Department of Veterans Affairs, 2009-2010**

The US Department of Veterans Affairs (VA) is the nation's largest single provider of human immunodeficiency virus (HIV) care. Veterans with HIV infection in VA care receive HIV care at all 152 VA Medical Centers (VAMCs) and throughout all 21 of the VA's Veterans Integrated Service Networks (VISNs). To date, nearly 64 000 Veterans have received HIV care in the VA, and in 2009, more than 24 000 Veterans with HIV were receiving care at the VA.<sup>1</sup>

Congressional repeal of long-standing requirements barring widespread HIV testing and requiring written informed consent allowed for change in VA HIV testing policy. In August 2009, the VA aligned its HIV testing policies with the 2006 recommendations on HIV testing by the US Centers for Disease Control and Prevention<sup>2</sup> to offer voluntary HIV testing to all veterans, regardless of age, as part of routine health care at least once, and annually for those veterans with ongoing risk factors. These policy changes also allowed informed consent for such testing to be obtained verbally at VAMCs, regardless of individual state law.

*See pages 12 and 20*

In late 2009, as part of its operational mission, the VA's Office of Public Health (OPH) deployed a validated, standardized application to collect HIV testing information from the electronic health record (EHR) at all VAMCs for quality improvement purposes, representing the first time that VA has systematically collected and reported national HIV testing data. Using this application, we determined VA HIV testing rates for 2009 and 2010.

**Methods.** The application reported the number of all unique patients who had had an outpatient visit at a given VAMC, the number who had ever had an HIV test, the number who had an HIV test in that calendar year, and the number with positive test results in that year. Data were analyzed at the VAMC, VISN, and national level. This Research Letter presents national level data; data are reported without attempt to assess causality or quantify specific impact of the change in pertinent federal law and VA policy or evaluate quality improvement interventions directed at increasing HIV testing rates.

**Results.** The **Table** provides a summary of the 2009 and 2010 data. In 2009, there were 5 713 265 veterans with at least 1 outpatient visit; 9.2% (524 267) had documentation of HIV testing ever being performed, and 2.5% (142 345) received an HIV test during that calendar year. Of those tested in 2009, 1.2% (1739) had a positive HIV test result. In 2010, 5 888 599 veterans had at least 1 outpatient visit; 13.5% (795 126) had ever been tested for HIV in their lifetime, and 5.8% (341 414) received an HIV test during that calendar year. Of the 341 414 veterans tested for HIV, 0.7% (2233) had a positive test result.

**Comment.** In this Research Letter, we provide the annual HIV testing rates and results for 2009 and 2010 in the VA. Overall, the VA saw an increase in HIV testing from 2009 to 2010, with a 47% increase in both the proportion of veterans ever tested for HIV (9.2% to 13.5%) and a 132% increase in proportion of veterans tested in the calendar year (2.5% to 5.8%).

The data presented in this Research Letter were systematically collected using a validated software application, creating reports via automated electronic extraction from the EHR. This is the first time the VA has performed and reported such an analysis, providing a baseline assessment for future data collection.

There are several limitations to this report. First, the data are only unique at the VAMC level; if a veteran received 1 HIV test at 1 VAMC and then received another one at a different VAMC during the same calendar year, that patient would be counted twice in merged data. We do not believe this is a major source of inaccuracy, especially since clinicians at each VAMC are able to view EHR data obtained at other VAMCs, including HIV testing results, and avoid unnecessary test duplication. In addition, to be included in this analysis, a veteran must have had 1 outpatient visit in the calendar year. It is possible that there are some veterans enrolled in VA care who may not have had an outpatient visit in 2009 and/or 2010 and would not be included in this analysis for 1 or both years.

**Table. US Department of Veterans Affairs National HIV Testing Data for 2009 and 2010**

Variable	2009	2010
Veterans with an outpatient visit, No.	5 713 265	5 888 599
Veterans with an outpatient visit ever tested for HIV, No. (%)	524 267 (9.2)	795 126 (13.5)
HIV tests performed in CY, No.	142 345	341 414
HIV positive test results, No.	1739	2233
Seropositivity of those tested in CY, %	1.2	0.7

Abbreviations: CY, calendar year; HIV, human immunodeficiency virus.

In conclusion, the VA has increased its HIV testing from 2009 to 2010; however, there is still room for improvement. It is current VA policy that every veteran be offered HIV testing at least once in a lifetime, regardless of risk factors and age, and that all veterans identified as HIV positive be linked to high-quality comprehensive care in a timely manner. The VA's OPH will continue to collect annual HIV testing data and strive to improve HIV testing rates throughout the entire VA system.

James Halloran, RN, MSN, CNS  
Maggie Czarnogorski, MD  
Erin K. Dursa, PhD, MPH  
Bryan D. Volpp, MD  
Janet M. Durfee, RN, MSN, APRN  
Ronald O. Valdiserri, MD, MPH  
Victoria J. Davey, PhD, MPH, RN  
David Ross, MD, PhD

**Published Online:** October 24, 2011. doi:10.1001/archinternmed.2011.510

**Author Affiliations:** Department of Veterans Affairs, Office of Public Health, Washington, DC (Mr Halloran; Drs Czarnogorski, Dursa, Davey, and Ross; and Ms Durfee); Department of Veterans Affairs, Veterans Affairs Northern California Health Care System, Washington, DC (Dr Volpp); and Department of Health and Human Services, Office of the Assistant Secretary for Health, Washington, DC (Dr Valdiserri).

**Correspondence:** Dr Czarnogorski, Office of Public Health and Environmental Hazards, Department of Veterans Affairs, 810 Vermont Ave NW, 10P3B, Washington, DC 20420 (Maggie.Czarnogorski@va.gov).

**Author Contributions:** Mr Halloran and Dr Dursa had full access to all the data in the study and take responsibility for the integrity of the data and the accuracy of the data analysis. *Study concept and design:* Halloran, Czarnogorski, Dursa, Durfee, Valdiserri, Davey, and Ross. *Acquisition of data:* Halloran, Czarnogorski, Dursa, and Volpp. *Analysis and interpretation of data:* Halloran, Czarnogorski, Dursa, Volpp, Valdiserri, Davey, and Ross. *Drafting of the manuscript:* Czarnogorski and Dursa. *Critical revision of the manuscript for important intellectual content:* Halloran, Czarnogorski, Volpp, Durfee, Valdiserri, Davey, and Ross. *Statistical analysis:* Dursa, Volpp, and Ross. *Obtained funding:* Ross. *Administrative, technical, and material support:* Halloran, Dursa, and Valdiserri. *Study supervision:* Czarnogorski, Durfee, Valdiserri, Davey, and Ross.

**Financial Disclosure:** None reported.

**Funding/Support:** This study was not supported by external funding.

**Role of the Sponsors:** The Office of Public Health, Department of Veterans Affairs, reviewed and approved this article before submission.

**Additional Contributions:** We acknowledge the contribution of the technical support staff at VA facilities who installed the electronic data extract routine to produce reports and laboratory directors and HIV lead clinicians at each facility who reviewed locally generated reports prior to submission.

1. Public Health Strategic Healthcare Group. The state of care for veterans with HIV. December 2009. <http://www.hiv.va.gov/provider/state-of-care/index.asp>. Accessed April 24, 2011.
2. Branson B, Hansfield H, Lampe M, et al. Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings. *MMWR Recomm Rep*. 2006;55(RR-14):1-17.

## LESS IS MORE

### Older Patient Experiences in the Mammography Decision-Making Process

The benefit of mammography for breast cancer screening among women older than 75 years is unclear owing to competing comorbidity and lack of evidence.<sup>1</sup> In this area of uncertainty, an individualized approach to cancer screening that considers a patient's age, health status, and preferences is desirable.<sup>2</sup> Such an approach would optimize screening practices and avoid screening women unlikely to benefit; a phenomenon that may apply to 2 of every 5 mammograms in this age group.<sup>3</sup>

When considering cancer screening, shared decision making is particularly important for older persons. In the absence of evidence-based recommendations, patients should have the opportunity to discuss the pros and cons of screening with their health care providers. Individualizing cancer screening in this age group requires a balanced patient-provider conversation that considers patients' overall health, communicates the potential benefits and adverse outcomes of screening, and elicits patients' preferences. We conducted this study to (1) describe the patient-provider conversation surrounding screening mammography among women older than 75 years and (2) evaluate if the patients' perceptions of their health care providers' screening recommendations varied according to age and health status.

**Methods.** We analyzed responses from the breast cancer screening module within the DECISIONS study, a national random-digit dial telephone survey with a 51% weighted response rate, conducted between 2006 and 2007.<sup>4</sup> Respondents were limited to those 40 years and older without a history of breast cancer. A complete description of the survey design, including questions, response scales, and survey weights, is available from the Inter-University Consortium for Political and Social Research.<sup>4</sup>

To account for the sampling design, weighted frequency comparisons were performed using PROC SURVEYFREQ (SAS version 9.2; SAS Institute Inc). These analyses compared the frequency with which women discussed reasons to have or not have a mammogram, whether their preferences were elicited, and if a physician recommendation was given across age (40-74 vs  $\geq 75$  years) and self-reported health (excellent to good vs fair to poor) groups.

**Results.** Responses from 873 women were included; 10% were 75 years or older. Most women were white, had at least a high school education, and were insured. Annual